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FISCAL IMPACT STATEMENT

LS 7280
BILL NUMBER: SB 559

NOTE PREPARED: Apr 15, 2013
BILL AMENDED: Apr 11, 2013

SUBJECT: Fraud.

FIRST AUTHOR: Sen. Hershman
FIRST SPONSOR: Rep. Turner

BILL STATUS: As Passed House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State & Local

Summary of Legislation: This bill does the following.

Medicaid False Claims and Whistleblower Protection: This bill establishes procedures for filing a civil action on behalf of the state to recover money owed to the state, plus civil penalties and damages, due to the filing of a false claim under the Medicaid program. It provides that the Attorney General and the Inspector General have concurrent jurisdiction to investigate such false claims. The bill permits an individual to file a civil action concerning false Medicaid claims on behalf of the individual and the state, and specifies the amounts an individual is entitled to receive if the state prevails in the action. Under certain conditions, the bill allows the Attorney General or the Inspector General to intervene in an action filed by an individual or to seek dismissal of that action. The bill also provides enhanced relief for a whistleblower who has been retaliated against by an employer for assisting in an investigation concerning a false Medicaid claim.

Release of Medicaid Information: The bill includes pharmacy benefit managers in the definition of "insurer" for purposes of releasing specified information to the Office of Medicaid Policy and Planning (OMPP) and the office's agents.

Data Sharing of the Fraudulent Identities, Deaths, and Inmate Status: The bill specifies that all state agencies shall cooperate with the Department of State Revenue (DOR) in tax administration by providing, at no charge to the DOR, relevant information that the DOR requests, including monthly reports identifying the use of a fraudulent identity. The bill requires the Department of Correction (DOC) to annually provide to the DOR an electronic file listing the name and Social Security number of each individual under the jurisdiction of the DOC. The bill also requires the Indiana State Department of Health (ISDH) to annually provide to the DOR an

electronic file listing the name of each individual for whom an Indiana death certificate was issued during the last year.

Medicaid Fraud Ineligibility Time Frame: The bill sets forth the Medicaid ineligibility time frame for a person who is convicted of forgery, fraud, legend drug deception, and other deceptions related to the application for or receipt of Medicaid assistance.

State Excise Police: The bill requires the State Excise Police to investigate allegations of electronic benefit transfer (EBT) fraud.

ATMs in Prohibited Locations: The bill requires an owner, vendor, or third-party processor of an automated teller machine (ATM) or point-of-sale terminal to disable access to electronic cash assistance benefits in specified prohibited locations. It requires the Division of Family Resources (DFR) to assist owners, vendors, and third-party processors in carrying out this provision. The bill also makes it a Class B infraction for a person to violate these provisions.

Replacement EBT Cards: The bill requires the Division of Family Resources (DFR) to establish a process for certain recipients to follow in order to receive a replacement EBT card.

Transportation Provider Surety Bonds: The bill requires a transportation provider that applies to enroll in the Medicaid program to file with the Office of Medicaid Policy and Planning a surety bond to be used for specified purposes. It provides certain exceptions.

Medicaid Providers: The bill requires the OMPP to visit certain Medicaid providers and provider applicants if certain conditions are met. It also requires a national criminal history background check on certain Medicaid provider applicants at the cost of the applicant.

School Lunch Program Participation Audit: The bill allows an audit and inspection of completed lunch school program applications to ensure that applicants meet the requirements to participate in the program.

Effective Date: July 1, 2013.

Summary of NET State Impact: *Medicaid False Claims and Whistleblower Protection:* The Attorney General's (AG) Office has reported that if the state is not in compliance with the federal Medicaid false claims and whistleblower requirements by August 31, 2013, a 10% incentive for Medicaid fraud recoveries made by the Medicaid Fraud Unit would no longer be retained by the state. If Medicaid fraud recoveries average $22 M each year, losing the 10% incentive would result in an annual reduction in state revenue of approximately $2.2 M.

Release of Medicaid Information: The bill includes pharmacy benefit managers in the definition of "insurer" for purposes of releasing specified Medicaid information. This provision should have no fiscal impact on the Medicaid program.

Health Finance Commission Study: The bill requires the Health Finance Commission to study, during the 2013 legislative interim, issues concerning the Medicaid false claims and whistleblower protection provisions added by the bill. If the Commission were to hold additional meetings to address this topic, there would be additional

expenditures for legislator per diem and travel reimbursement. Any additional expenditures must be within the Commission's budget, which is established by the Legislative Council.

Data Sharing of the Fraudulent Identities, Deaths, and Inmate Status: The requirements of the bill should be able to be implemented within the current level of resources available to the affected agencies.

State Excise Police: It is not known at this time what level of resources the Indiana Excise Police may have to conduct investigations of alleged EBT fraud.

ATMs in Prohibited Locations: The bill establishes a Class B infraction for owners, vendors, or third-party processors of ATMs or point-of-sale terminals that fail to disable access to cash assistance benefits in prohibited locations. The maximum judgment for a Class B infraction is $1,000, which would be deposited in the state General Fund. However, any additional revenue is likely to be small.

Replacement EBT Cards: It is not known at this time if the DFR can track the number of replacement cards an individual has requested in the specified time frame or what resources might be necessary to implement this provision.

School Lunch Program Participation Audit: This requirement should have no fiscal impact since the federal Food and Nutrition Service currently audits the participation compliance in the federal free and reduced lunch program.

Medicaid Providers: The bill requires OMPP to visit the business locations of Medicaid providers under specified conditions and requires specified providers to obtain national criminal history background checks at the provider's expense under certain conditions. These provisions are similar to federal regulations currently in place so should have minimal fiscal impact on the OMPP.

Transportation Provider Surety Bonds: The level of resources required by FSSA and OMPP to implement the surety bond requirement for Medicaid providers is not known at this time, although other providers are required to maintain surety bonds as a condition for providing Medicaid or Medicare services. Medicaid administrative expenditures are generally matched by 50% federal funds. Recoveries would be split between the federal and state Medicaid programs in the same percentage as the contested claim. The Attorney General's office has estimated that if the surety bond requirement had been in place during the last five years, the amount owed to the state would have been reduced by 20.7%, or $476,465.

Medicaid Fraud Ineligibility Time Frame: The fiscal impact of this provision would depend on individual circumstances, sentences, and the number of persons convicted of forgery, fraud, legend drug deception, and other deceptions related to the application for or receipt of Medicaid assistance.

Explanation of State Expenditures: *ATMs in Prohibited Locations:* The bill requires the DFR to provide assistance to an ATM or point-of-sale machine owner, vendor, or third-party processor with this provision. FSSA reports that there will be no fiscal impact to this provision.

There are no known data (1) concerning the frequency that individuals have accessed TANF cash assistance from ATMs or point-of-sale terminals at venues currently required to post signs that access is prohibited; or (2) indicating whether any individuals or establishments have been charged with the current Class C

misdemeanor for violation of the existing statute. The Division of Family Resources reported that currently the EBT vendor can work with ATM owners to block ATMs and point-of-sale machines in certain locations. However, it is the ATM or point-of-sale owner that blocks the transactions, not the EBT vendor.

Data Sharing of the Fraudulent Identities: All state agencies would incur some cost to provide the DOR with incidences of fraudulent identities in an electronic format. There would be additional expenses in the collection and transmission of the data. The precise cost depends on the format specified by the DOR and the information technology resources of the other state agencies.

The bill's requirements are within the DOR's routine administrative functions and should be able to be implemented with no additional appropriations, assuming near customary agency staffing and resource levels.

State Excise Police: The bill requires the State Excise Police to investigate allegations of fraud within the EBT program and to investigate applicants, recipients, retailers, and individuals who sell or purchase EBT cards fraudulently. The EBT program is used to distribute Temporary Assistance to Needy Families (TANF) grants and Supplemental Nutrition Assistance Program (SNAP) benefits. SNAP benefits are limited to sales with authorized retailers; TANF grants are for cash assistance. In June 2012, there were about 403,000 households and 909,000 recipients receiving SNAP assistance, and about 15,500 households and 37,600 individuals receiving TANF grants. The number of retailers that participate in the EBT program or the level of resources the Indiana Excise Police may have to conduct investigations of alleged EBT fraud are not known at this time.

Replacement EBT Cards: The bill requires the DFR to establish a process to follow in order for a recipient to receive a replacement EBT card until such time that federal rules are adopted replacing the process developed by the DFR. (A proposed rule was published in May 2012.) The process must require that if a recipient has requested a replacement card at least four times within the prior 12-month period, contact with the local DFR office is required. Further, the bill allows the DFR to hold the replacement of a card if the individual does not follow the procedure established. It is not known at this time if DFR can track the number of replacement cards an individual has requested in the specified time frame or what resources might be necessary to implement this provision. [This information will be provided when it is available from FSSA.]

School Lunch Program Participation Audit: The bill requires an audit, inspection, or administrative review of applications for the school lunch program to ensure that applicants meet the requirements to participate in the program. This requirement should have no fiscal impact since the federal Food and Nutrition service currently audits the participation compliance in the federal free and reduced lunch program.

Transportation Provider Surety Bonds: The bill would after July 1, 2013, require certain for-profit common carriers newly applying for Medicaid provider status to furnish with the application an authorized surety bond that would provide coverage for liability of at least $50,000. The bill provides for certain exceptions and allows the Secretary of FSSA to waive the bond requirements in certain situations. The bill provides that if a surety bond does not meet the specified requirements, OMPP may revoke or deny the provider's billing privileges. If a lapse or gap in bond coverage occurs, OMPP is required to revoke the provider's billing privileges. The bill provides that OMPP may not reimburse a Medicaid provider for services provided during the lapse or gap in coverage.

The level of resources required by FSSA and OMPP to implement the surety bond requirement for Medicaid providers is not known at this time, although other providers are required to maintain surety bonds as a condition for providing Medicaid or Medicare services. Medicaid administrative expenditures are generally

matched by 50% federal funds. Recoveries would be split between the federal and state Medicaid programs in the same percentage as the contested claim.

Medicaid Fraud Ineligibility Time Frame: The bill would allow persons convicted of Medicaid fraud one or two times to receive Medicaid services sooner than is provided for in current statute. The fiscal impact of this provision would depend on individual circumstances, sentences, and the number of persons convicted of forgery, fraud, legend drug deception, and other deceptions related to the application for or receipt of Medicaid assistance. Family and Social Services Administration data indicates that nine individuals were convicted of Medicaid member fraud in CY 2011.

The existing Class A misdemeanor applies to welfare fraud convictions of first-time offenders that involve public assistance amounts of less than $250. All other existing criminal penalties applying to amounts of welfare fraud over $250 constitute Class D or Class C felonies. The bill adds legend drug deception to the offenses for which Medicaid eligibility shall be suspended. Legend drug deception penalties are Class D and Class C felonies unless the commission results in death, in which case it is a Class A felony. Persons with convictions for forgery, fraud, legend drug deception, and other deceptions related to the application for or receipt of Medicaid assistance would be ineligible to receive medical assistance for: (1) 1 year for a first offense; (2) 2 years for a second offense; and (3) 10 years if the conviction is for a third or subsequent offense. Convictions for Medicaid member fraud appear to be limited. There were 11 such offenses in CY 2010 and nine in CY 2011, so the most likely period of ineligibility would be one year.

The bill would also allow the Office of Medicaid Policy and Planning (OMPP) to adopt rules establishing a process to suspend a person from receiving medical assistance if a reasonable suspicion exists that the person engaged in welfare fraud. OMPP should be able to promulgate rules within the level of resources currently available. If an investigation determines that an individual fraudulently applied for or received public assistance and criminal prosecution is not an available avenue to pursue, an administrative hearing may be an appropriate process to order restitution and disqualify recipients from receiving benefits. The level of resources required to implement an administrative hearing process would depend on the rules promulgated and the number of cases that might be heard.

Background: OMPP reported that in CY 2010, 138 Medicaid member fraud cases were substantiated by the Bureau of Investigations within the Family and Social Services Administration (FSSA). Of the total, 24 cases were prosecuted with 11 receiving felony convictions. The court ordered restitutions of $24,554.

OMPP reported that in CY 2011, 24 Medicaid member fraud cases were substantiated by the Bureau of Investigations within FSSA. Of the total, 12 cases were prosecuted with 9 receiving felony convictions. The court ordered restitutions of $122,518.

OMPP reported that the agency cannot prosecute cases, being dependent on local prosecutors to take the cases. Further, the OMPP may not have sufficient evidence to meet the prosecutorial level needed to file a case in court.

Medicaid is jointly funded by the state and federal governments. The effective state share of program expenditures is approximately 33% for most services. Medicaid medical services are matched by the effective federal match rate (FMAP) in Indiana at approximately 67%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: *Medicaid False Claims and Whistleblower Protection:* Federal law provides for an increase of 10% in the state share of any amounts recovered under a Medicaid False Claims Act that meets the provisions of various federal law provisions. The Attorney General has been notified that without the proposed amendment, Indiana will be out of compliance with the federal requirements and after August 31, 2013, will no longer be eligible for the 10% incentive money. If Medicaid fraud recoveries average $22 M each year, losing the 10% incentive would result in an annual reduction in state revenue of approximately $2.2 M.

Penalty Provision - ATMs in Prohibited Locations: The bill establishes a Class B infraction for owners, vendors, or third-party processors of ATMs or point-of-sale terminals who fail to disable access to cash assistance benefits in prohibited locations. The maximum judgment for a Class B infraction is $1,000, which would be deposited in the state General Fund. However, any additional revenue is likely to be small.

Data Sharing of the Fraudulent Identities: The sharing of fraudulent identities will be used by the DOR for tax administration purposes, specifically to identify fraudulent taxpayers. This could lead to an indeterminable increase in revenue, depending on how the DOR uses the information. The bill does not restrict the use of the information to a specific tax type. The increased revenue would be deposited in the fund appropriate for the tax.

Transportation Provider Surety Bonds: By requiring surety bonds for Medicaid transportation providers, OMPP and the Attorney General's office could increase recoveries for overpayments and reimbursements made for fraudulent claims. The Attorney General's office has estimated that if the surety bond requirement had been in place during the last five years, the amount owed to the state would have been reduced by 20.7%, or $476,465. Additionally, 50% of the fraud cases resolved could have been closed immediately, saving the cost of tracking and administering the settlements. The bill requires only new applicants to provide the surety bond, so recoveries may be somewhat less since existing providers would not be required to provide a bond. The Attorney General's office reported that for 2009, there were 240 enrolled Medicaid providers: 186 ambulatory common carriers, 41 nonambulatory common carriers, and 15 taxis.

Background Information on Surety Bond: The bill would require certain for-profit common carriers that apply for Medicaid provider status to furnish OMPP with an authorized surety bond before the provider can receive reimbursement. The Centers for Medicare and Medicaid Services (CMS) has estimated the average annual cost of a surety bond at 3% of its face value, or about $1,500 for a $50,000 bond. The Attorney General's office has estimated the cost to be about $300 annually. However, surety bond cost is generally related to individual factors relating to the bondholder's risk, such as credit rating, length of time in business, or prior adverse actions, so bond prices would vary depending on the buyer and the amount of the bond required. If a transportation Medicaid provider has had a criminal conviction, a civil judgement, or an exclusion action related to Medicaid provider services within the preceding 10 years, the bill requires an additional authorized surety bond as determined by OMPP.

State contracts with the managed care organizations (MCOs) currently require the organizations to provide a bond in the amount of $1 M. It is not known how many other contracted Medicaid providers are required to provide a bond as a term of the contract. Medicare regulations require certain other providers to furnish surety bonds for Medicare purposes. Home health agencies are required to furnish surety bonds to Medicare and Medicaid.

Explanation of Local Expenditures: *Medicaid Fraud Ineligibility Time Frame:* Township poor relief may

have fewer requests to furnish medical goods or services for indigent persons under suspension of eligibility for Medicaid benefits. (See *Explanation of State Expenditures* above.)

Explanation of Local Revenues: *Penalty Provision:* If additional court actions are filed and a judgment is entered, local governments would receive revenue from court fees. However, any additional revenue is likely to be small.

State Agencies Affected: OMPP, Division of Family Resources, FSSA; Attorney General; State Excise Police; Department of Revenue; ISDH; DOC.

Local Agencies Affected: Township trustees. Trial courts, local law enforcement agencies.

Information Sources: FSSA; Attorney General; CMS state Medicaid letters and press releases.

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